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OFFICE OF THE

No. 15-274

IN THE

Supreme Court of the United States

WHOLE WOMAN'S HEALTH, et al.,

Petitioners,

v.

JOHN HELLERSTEDT, M.D., et al.,

Respondents.

On Writ of Certiorari to the U. S. Court of Appeals for the Fifth Circuit

BRIEF OF *AMICI CURIAE* STATES OF INDIANA, OHIO, ALABAMA, ARIZONA, ARKANSAS, FLORIDA, GEORGIA, IDAHO, KANSAS, LOUISIANA, MICHIGAN, MISSISSIPPI, MONTANA, NEBRASKA, NEVADA, NORTH DAKOTA, OKLAHOMA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, AND WYOMING IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

May a State, consistent with the Fourteenth Amendment, subject abortion facilities to medical licensing regulations and require abortion doctors to have admitting privileges with nearby hospitals, even if the therapeutic justifications for such laws are disputed, and even if some clinics close because of them?

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Planned Parenthood of Wis., Inc. v. Schimel,
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Stenberg v. Carhart,
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CASES [CONT'D]

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N.J. Admin. Code § 8:43A-3.6(a)(6) 16

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N.J. Admin. Code § 8:43A-17.1 10

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ACOG, Statement on State Legislation Requiring Hospital Admitting Privileges for Physicians Providing Abortion Services (Aug. 25, 2013), *available at* http://www.acog.org/About-ACOG/News-Room/News-Releases/2013/Hospital-Admitting-Privileges-for-Physicians-Providing-Abortion-Services 13, 14

Am. Ass'n for Accreditation of Ambulatory Surgery Facilities, 2014 Checklist, *available at* http://www.aaaasf.org/Surveyor/asf_web/PDF%20FILES/Standards%20and%20Checklist%20Manual%20V14.pdf 12, 13

AMA, H-475.984 Office-Based Surgery Regulation, *available at* http://www.ama-assn.org/resources/html/PolicyFinder/policyfiles/HnE/H-475.984.HTM 13

Guttmacher Inst., State Policies in Brief (Jan. 1, 2016), https:// www. guttmacher.org/statecenter/spibs/spib_TRAP.pdf 10

Grand Jury Rpt., *In re Cnty. Investigating Grand Jury XXIII* (1st Jud. Dist. Pa. Jan. 14, 2011), *available at* 2011 WL 711902 11

OTHER AUTHORITIES [CONT'D]

Joint Commission, 2012 Comprehensive Accreditation Manual for Ambulatory Care at PC-23 & 24 13

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INTEREST OF THE *AMICI* STATES

Like Texas, many States regulate outpatient medical facilities, including those that perform abortions, to protect health and safety. As detailed in Part I of this brief, States have set standards for buildings and equipment, for doctor and staff credentials, and for emergency plans. As detailed in Part II, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), permits these laws. Petitioners' views, by contrast, would handcuff the States' ability to regulate medicine in furtherance of patient safety and mire the States in unending litigation. The *amici* States file this brief to support their traditional role in protecting patients and upholding public health.

SUMMARY OF THE ARGUMENT

I. The Court has always recognized the States' interest in regulating health and safety—for all patients, including women seeking abortions. It has identified, as obvious areas for state oversight, the regulation of doctors and their staff, of medical facilities, and of emergency plans. While the Court's pre-*Casey* regime gave inadequate weight to these important state interests, the Court has since left the States wide discretion to enact health and safety regulations, even in the abortion context.

Acting according to the police powers that were reaffirmed in *Casey*, many States regulate abortion facilities in the same general ways to protect public health. Some, like Ohio, have for decades treated

abortion clinics like other ambulatory surgical centers. Others, like Texas, had left abortion clinics *less* regulated, but reassessed their laws after revelations that a Philadelphia doctor, Kermit Gosnell, exploited a lack of oversight to commit heinous crimes. Many States have also long required outpatient clinics, including abortion clinics, to have plans in place for transferring a patient to a hospital in the event of an emergency. Indeed, there is a general consensus—illustrated by the federal Medicare laws—that outpatient clinics should have either doctors with admitting privileges at a local hospital or a written transfer agreement with that hospital, or both.

Petitioners' arguments against Texas's health and safety regulations here resemble this Court's pre-*Casey* standards in which abortion doctors, alone among medical professionals, had the unique right to practice medicine with unfettered discretion. If the Court accepts their arguments, it will reinvigorate those overruled standards.

II. Properly applied, *Casey* supports Texas's health and safety regulations.

First, *Casey* involved abortion-*specific* laws, so the abortion-*neutral* laws that States have enacted in this area should remain subject only to rational-basis review. Indeed, neutral laws affecting other constitutional rights—free speech, free exercise, or equal protection—typically face rational-basis review alone.

Second, even for abortion-specific laws that trigger *Casey*, courts should analyze the *need* for a proposed law under rational-basis review, asking whether the law reasonably relates to a plausible interest in protecting health. And where scientific and medical evaluation over the need for the law is disputed, States may decide that it is appropriate.

Third, *Casey*'s undue burden test centers on a medical regulation's effect on "a *woman*'s ability to make [the] decision" to have an abortion, not on an *abortion clinic*'s ability to practice its trade. That is, a "substantial obstacle" arises only when a medical-procedure regulation necessarily impinges the abortion decision *itself*, not merely when the regulation would lead to some effect on abortion "access" when combined with countless other variables. A regulation that promotes health is valid even if it may combine with other unknown (and unknowable) factors to increase the cost of abortions or reduce the aggregate number of clinics.

Fourth, the conclusion that the undue burden test applies only to laws that directly interfere with a woman's decision to have an abortion best harmonizes *Casey* with *Salerno*'s standard for facial constitutional challenges. That is, *Casey*'s "undue burden" test should apply only to whether *specific* abortion regulations—such as spousal notification laws, informed consent requirements without health exceptions, or parental notice without judicial bypass provisions—*by themselves* interfere with a woman's ultimate decision. *Salerno*, by contrast, should apply

to cases like this one that seek invalidation based on aggregate reduced "access" that varies among States.

Finally, Petitioners' case fails on its own terms for lack of evidentiary support. They argue that Texas laws will prevent some women from having abortions because many providers have gone out of business. Clinic closures alone, however, do not prove that any woman has been unable to obtain a timely abortion. Admitting privilege and transfer agreement laws have been in effect for some time, so if such laws actually prevented women from having abortions, ample evidence of such an effect should be available. But Petitioners cite none.

ARGUMENT

I. States Have Long Regulated Healthcare Facilities, Including Those That Perform Abortions, To Protect Public Health

The Court has repeatedly affirmed the States' ability to enact health-and-safety regulations for medical professionals, including in the abortion context. In recent decades, as more physicians have switched to outpatient care, many States have enacted laws—similar in many ways to those challenged here—that regulate abortion clinics along with other "ambulatory surgical centers." Petitioners' view that the Constitution should exempt abortion clinics from outpatient care regulations would return the Court to the days before *Casey*, when it gave abortion doctors unfettered choice in their medical practices.

A. The Court has always recognized the States' interest in the health and safety of their citizens, including citizens contemplating abortions

Since the Nation's founding, the Court has noted that "the structure and limitations of federalism" "allow the States 'great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons.'" *Gonzales v. Oregon*, 546 U.S. 243, 270 (2006) ("*Oregon*") (citation omitted). This police power reaches its apex in the medical arena. Even at the time of *Lochner v. New York*, 198 U.S. 45 (1905), the Court rejected challenges to state medical regulations, explaining that "[f]ew professions require more careful preparation by one who seeks to enter it than that of medicine." *Dent v. West Virginia*, 129 U.S. 114, 122 (1889); *Collins v. Texas*, 223 U.S. 288, 288–89 (1912). Instead, the Court held that a State may "prescribe all such regulations as in its judgment will secure or tend to secure [its citizens] against the consequences of ignorance and incapacity" in those who practice medicine. *Dent*, 129 U.S. at 122.

These concerns extend to those who perform abortions just as much as they do to all other medical professionals. Indeed, when the Court first established the abortion right, it agreed that the States have a "legitimate interest" in ensuring that "abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Roe v. Wade*, 410

U.S. 113, 150 (1973). That interest extended "at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise." *Id.* From the beginning, therefore, *Roe* made clear that the "obvious[]" area of state regulatory concern included the doctors and their staff, the facilities, and the need for emergency planning. *Id.*

Despite *Roe*'s promise, at the height of its strict trimester regime, the Court seemed to be "functioning as the nation's '*ex officio* medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States.'" *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 456 (1983) (O'Connor, J., dissenting) (citation omitted). Even when acting in that role, the Court *upheld* a state law requiring physicians to perform second-trimester abortions in outpatient facilities that met "the same regulations applicable to all outpatient surgical hospitals." *Simopoulos v. Virginia*, 462 U.S. 506, 515 (1983). Yet it struck down a city ordinance requiring physicians to perform second-trimester abortions in *hospitals*, pointing out, among other things, that the American Congress of Obstetricians and Gynecologists (ACOG) "no longer suggest[ed]" it. *Akron*, 462 U.S. at 437; *cf. id.* at 456 (O'Connor, J., dissenting) (criticizing the majority for "believ[ing] that this Court, without the resources available to those bodies entrusted with making legislative choices, [is] itself competent to make these inquiries

and to revise these standards every time [ACOG] or [a] similar group revises its views").

The Court's balance in *Casey* abandoned this approach, one that gave abortion doctors preferential treatment over other medical professionals. *Casey* instead held that, "[a]s with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 878 (1992). Those regulations are valid, it explained, so long as they are not "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion"—regardless of the impacts that the regulations have on physicians. *Id.* *Casey* thus overruled *Akron*'s decision to invalidate a physician-disclosure requirement because *Akron* had wrongly focused on the burdens imposed on *physicians*, but the right belongs to the *woman*. *Id.* at 884–85. After *Casey*, therefore, "[t]he law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007).

B. Many States regulate abortion facilities to further health and safety interests

Many States regulate abortion facilities in some way, whether by addressing them specifically, or by including them within general health and safety laws. The two Texas provisions here fall within this

regulatory rubric. Texas's *general* requirement that abortion clinics follow the same rules as ambulatory surgery centers furthers patient safety in the outpatient setting. And its *specific* requirement that abortion doctors have admitting privileges at local hospitals maximizes safety in the event of complications requiring emergency hospital care.

1. States expanded their regulation of outpatient clinics, including abortion clinics, as those clinics have grown

Historically, physicians performed most surgeries in the hospital setting. Madelyn Quattrone, *Is the Physician Office the Wild, Wild West of Health Care?*, 23(2) J. Ambulatory Care Management at 64 (Apr. 2000); *cf. Roe*, 410 U.S. at 143–46. In the past several decades, however, the location of many procedures has shifted from full-service hospitals to outpatient clinics. Quattrone, *supra*, at 64. By 1980, Congress, accounting for this transition, amended the federal healthcare laws by permitting independent "ambulatory surgical centers" to receive Medicare reimbursement if they meet certain health and safety standards. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 934, 94 Stat. 2599, 2637 (codified at 42 U.S.C. § 1395k(a)(2)(F)).

States began to regulate these entities too. Some have regulated abortion clinics like other facilities for decades. *Cf. Simopoulos*, 462 U.S. at 515–16. In 1978, for example, Michigan passed regulatory standards for all surgical outpatient facilities, including abortion clinics. *See* Mich. Comp. Laws

§§ 333.20104(5) (1978) (now codified as § 333.20104(7)), 333.20821. Yet, under *Roe*'s rigid trimester regime, the Sixth Circuit invalidated the portion of this law "governing the staffing, physical layout and equipment required" for these facilities *as applied* to abortion clinics. *Birth Control Ctrs., Inc. v. Reizen*, 743 F.2d 352, 364–66 (6th Cir. 1984). While recognizing that "[n]o suspect classification is involved here since the State has chosen to regulate all [surgical outpatient facilities], not just abortion clinics," the court still held that heightened scrutiny applied to any "regulations touching on a woman's right to an abortion *during the first trimester* of pregnancy." *Id.* at 358, 361 (emphasis added).

Three years after *Casey*, by contrast, Ohio enacted its law. 146 Ohio Laws 8144, 8145 (1995) (noting that the Act was "to establish accreditation standards for ambulatory surgical facilities"). Its definition of "ambulatory surgical facility" covers *all* facilities where "[o]utpatient surgery is routinely performed," Ohio Rev. Code § 3702.30(A)(1)(a), "including, but not limited to, cosmetic and laser surgery, plastic surgery, abortion, dermatology, digestive endoscopy, gastroenterology, lithotripsy, urology, and orthopedics." *Women's Med. Prof'l Corp. v. Baird*, 438 F.3d 595, 598 n.1 (6th Cir. 2006). Ohio now requires these facilities, including abortion clinics, to be licensed, Ohio Rev. Code § 3702.30(E), and its implementing regulations require these facilities to meet various standards or obtain waivers or variances, Ohio Admin. Code 3701-83-05(A); -14. Building and equipment rules require facilities to have particular equipment available, to separate

designated waiting and recovery rooms, and to have emergency power available in the event of an outage. *Id.* 3701-83-20. Facilities must also meet "service standards." *Id.* 3701-83-19. They shall, for example, "[e]nsure that all anesthetics are administered" properly by qualified individuals, maintain anesthesia records, have procedures for blood supplies, and so on. *Id.*

Over twenty States require abortion clinics to meet "[s]tructural [s]tandards [c]omparable to [t]hose for [s]urgical [c]enters." *See* Guttmacher Inst., State Policies in Brief (Jan. 1, 2016), https://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf. New Jersey, for example, requires all facilities, N.J. Admin. Code § 8:43A-1.1, to meet the same requirements for the physical building, *id.* § 8:43A-19.1–19.48, cleaning and maintenance, *id.* § 8:43A-17.1, and infection prevention and control, *id.* § 8:43A-14.1–14.7; *cf.* Cal. Code Regs. tit. 22 §§ 75047, 75060–61, 75064–69 (establishing various building, equipment, and sanitation requirements for all "clinics"); Cal. Health & Safety Code § 1200(a).

Perhaps because of the uncertainty caused by decisions like *Reizen*, some States have treated abortion facilities exceptionally, by regulating them *less* than other facilities. Texas and Pennsylvania, for example, both had specific categories of "abortion facilities" laws, allowing such facilities to be licensed without meeting the same standards applied to ambulatory surgical centers. *See* Tex. Health & Safety Code § 245.003; 18 Pa. Cons. Stat. § 3207.

Since 2011, however, many States have reconsidered this approach in light of the "shocking revelation of terrible conditions and procedures at an abortion clinic" in Philadelphia operated by Kermit Gosnell. *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 802 (7th Cir. 2013) (Manion, J., concurring in part and concurring in judgment). This clinic followed "egregious health care practices," including "bloody floors and unlicensed employees conducting gynecological examinations and administering painkillers, resulting in the death of a patient." *Id.* The grand jury reported that a climate of under-regulation contributed to the conditions, and recommended that the States hold abortion clinics to the same standards as any other ambulatory surgical facility. Grand Jury Rpt. at 16, *In re Cnty. Investigating Grand Jury XXIII* (1st Jud. Dist. Pa. Jan. 14, 2011), *available at* 2011 WL 711902.

Like Texas, many States have since revised their laws—by requiring their state agencies to "apply the same regulations" regarding such things as safety, personnel, and equipment that apply "to ambulatory surgical facilities." 35 Pa. Cons. Stat. § 448.806(h) (2011); *see, e.g.*, Ala. Code § 26-23E-9 (2013); Kan. Stat. § 65-4a09 (2011); Tenn. Code § 68-11-201(3) (2015); Va. Code Ann. § 32.1-127(B)(1) (2014).

2. States typically require emergency arrangements as part of their outpatient-center regulations

a. A broad consensus supports, as part of this general regulation of outpatient centers, requiring formal arrangements between the centers and local hospitals to transfer patients when complications arise. That consensus gives States two general options: (1) requiring a clinic doctor to have admitting privileges at a local hospital, or (2) requiring a clinic to enter into a written transfer agreement with a local hospital.

Federal Medicare law, for example, has long required a participating "ambulatory surgery center" to either have a written transfer agreement with a local hospital or "[e]nsure that all physicians performing surgery in the [center] have admitting privileges" at the hospital. 42 C.F.R. § 416.41(b). This requirement was adopted to "ensure that patients have immediate access to needed emergency or medical treatment in a hospital." 47 Fed. Reg. 34082, 34086 (Aug. 5, 1982); *but see* U.S. Br. 17 (noting that the admitting-privileges requirement is not "even useful" to protect health).

Accrediting organizations also suggest that ambulatory surgical centers have "a written transfer agreement with a local accredited or licensed acute care hospital within 30 Minutes," or require "the operating surgeon [to have] privileges to admit patients to such a hospital." *See, e.g.*, Am. Ass'n for Accreditation of Ambulatory Surgery Facilities, 2014

Checklist at 48, available at http://www.aaaasf.org/Surveyor/asf_web/PDF%20FILES/Standards%20and%20Checklist%20Manual%20V14.pdf; Joint Commission, 2012 Comprehensive Accreditation Manual for Ambulatory Care at PC-23 & 24 (noting that an ambulatory surgical center must have "a process that addresses the patient's need for continuing care, treatment or services after discharge," including "a written transfer agreement with a hospital").

Similarly, among the 2003 American College of Surgeons' core principles are that even physicians performing *office-based* surgeries "have admitting privileges at a nearby hospital, a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital." *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 928 (7th Cir. 2015) (Manion, J., dissenting) (citation omitted); *see* AMA, H-475.984 Office-Based Surgery Regulation, *available at* http://www.ama-assn.org/resources/html/PolicyFinder/policyfiles/HnE/H-475.984.HTM (same).

ACOG, too, supports such requirements for outpatient clinics so long as they are *neutral*. ACOG, Statement on State Legislation Requiring Hospital Admitting Privileges for Physicians Providing Abortion Services (Aug. 25, 2013), *available at* http://www.acog.org/About-ACOG/News-Room/News-Releases/2013/Hospital-Admitting-Privileges-for-Physicians-Providing-Abortion-Services ("[F]reestanding ambulatory care facilities should have a plan to ensure prompt

emergency services if a complication occurs and should establish a mechanism for transferring patients who require emergency treatment. However, ACOG opposes legislation or other requirements that single out abortion services from other outpatient procedures.").

In short, all agree that States should require ambulatory care centers to have *some* emergency plan to protect patients. Some might debate the *particular* requirements that best implement that goal. Yet such debate is quintessentially legislative and depends on many factors, many of which might be state-specific. *See Gonzales*, 550 U.S. at 166. If, for example, a State believes that a lack of physician proficiency has caused negative outcomes, a privilege requirement may work better at ensuring that the doctor performing the surgery is "'appropriately qualified, trained and competent.'" *Schimel*, 806 F.3d at 929–30 (Manion, J., dissenting) (citation omitted). If, on the other hand, a State believes that problems arose from a lack of administrative proficiency in transferring patients, a written transfer agreement may work better by comprehensively laying out the transfer's details, ranging from the handling of records to the logistics of the physical transport. *Cf.* 5 Wyo. Code R. § 7(g). Unsurprisingly, therefore, States have taken different approaches, depending on their distinct circumstances and judgments.

b. Most States generally require ambulatory surgical centers, including abortion clinics, to have emergency plans. Indeed, New York and California

agree with Alabama and Mississippi on this general point, though all of the States' details vary.

Admitting Privileges. Many States require abortion doctors to have privileges at local hospitals or agreements with doctors who do. Texas and eight other States recently enacted or amended abortion-specific privilege laws in response to "the nationwide attention that Dr. Gosnell's shop of horrors attracted"—an abortion-specific failure of oversight. *Schimel*, 806 F.3d at 924 (Manion, J., dissenting); *see, e.g.*, Ala. Code § 26-23E-4(c) (2013); Ariz. Rev. Stat. § 36-449.03(C)(3) (2012); Kan. Stat. § 65-4a08(b) (2011); La. Stat. Ann. § 40:1061.10(A)(2) (2014); Miss. Code § 41-75-1(f) (2012); N.D. Cent. Code § 14-02.1-04(1) (2013); Tenn. Code § 39-15-202(j)(1) (2012); Wis. Stat. § 253.095(2) (2013).

Other States had earlier enacted similar requirements. Missouri's law, for example, dates at least to 1986. *See* Mo. Rev. Stat. § 188.080. In upholding this law, even under *Roe*'s rigid regime, the Eighth Circuit accepted that the requirement "provide[d] for 'prompt emergency treatment or hospitalization in the event of complication' in accordance with the Standards for Obstetrics-Gynecologic Services 62–63 (6th ed. 1985) published by [ACOG]." *Women's Health Ctr. of West Cnty., Inc. v. Webster*, 871 F.2d 1377, 1381 (8th Cir. 1989); *see also, e.g.*, Okla. Admin. Code § 310:600-9-6(9) (requiring that attending physician have privileges at a local hospital or an agreement with a physician who does).

Of these States requiring admitting privileges for abortion clinics, many impose similar mandates on other facilities. Indiana, for example, requires abortion clinics to have an on-staff doctor with privileges or an arrangement with another doctor who does. Ind. Code § 16-34-2-4.5. In either case, the privileges must be at a hospital in the same or a contiguous county. All Indiana "ambulatory surgical clinics," by comparison, must have a staff doctor with admitting privileges at a "nearby" hospital or a similar arrangement with another doctor. 844 Ind. Admin. Code 5-5-22(a). The contiguous-county requirement for abortion clinics does not seem to materially differ from the "nearby" limit for other clinics. New York likewise requires many outpatient clinics, including abortion clinics, to have at least one physician on staff with admitting privileges at a hospital (along with a plan for transferring patients in emergencies). *See* N.Y. Comp. Codes R. & Regs. tit. 10, §§ 756.1(b), 756.4; *cf. id.* § 755.2(a), (d); *see also, e.g.*, N.J. Admin. Code §§ 8:43A-1.1(a); 8:43A-3.6(a)(6) (requiring "at least one member of the medical staff to maintain admitting privileges at a hospital" for *all* types of healthcare facilities).

Transfer Agreements. Other States instead require that outpatient facilities, including abortion clinics, have written transfer agreements with local hospitals. Some, like Ohio, have one law requiring *all* clinics to have a "written transfer agreement with a local hospital that specifies an effective procedure for the safe and immediate transfer of patients from the facility to the hospital when medical care beyond the care that can be provided at the ambulatory

surgical facility is necessary, including when emergency situations occur or medical complications arise." Ohio Rev. Code § 3702.303(A); Ohio Admin. Code 3701-83-19(E). Michigan, too, requires all "surgical outpatient facilities," including abortion clinics, to have "written emergency admission arrangements" with a hospital no more than 30 minutes away, Mich. Admin. Code r. 325.3832(d); *id.* 325.3802; *see also, e.g.*, Cal. Code Regs. tit. 22, § 75047(a).

Others have separate provisions that impose largely the same transfer-agreement commands on abortion clinics and outpatient centers. *Compare* Ky. Rev. Stat. Ann. § 216B.0435(1); 12 Va. Admin. Code § 5-412-290(B)–(C), *with* 902 Ky. Admin Regs. 20:074 § 7(3); 12 Va. Admin. Code § 5-410-1240(B)–(C).

Either or Both. Other States require a mixture of admitting privileges and/or transfer agreements. Utah, for example, requires abortion clinics, like other ambulatory surgical centers, to have at least one doctor with privileges at a nearby hospital or a transfer agreement with that hospital. *Compare* Utah Admin. Code r. 432-600-13(1)–(2)(a), *with* Utah Admin. Code r. 432-500-12(2); *see also, e.g.*, Fla. Stat. § 390.012(3)(c)(1); Fla. Admin. Code r. 64B8-9.009(4)(b). In Pennsylvania, many facilities may pick either option, 28 Pa. Code § 555.23(d)–(f), but abortion facilities must have transfer agreements, 28 Pa. Code § 29.33(10). South Carolina requires the inverse, letting abortion facilities choose, S.C. Code Ann. Regs. 61-12.305(A), while requiring other

facilities to have physicians with admitting privileges, S.C. Code. Ann. Regs. 61-91.504(E).

In short, most States regulate in this area, many in ways similar to Texas's regulations in this case.

C. Petitioners seek uniquely unfettered discretion for abortion doctors

As shown above, States now exercise the "'great latitude'" that they have "'under their police powers'" to adopt an array of approaches for regulating outpatient facilities, including abortion clinics. *See Oregon*, 546 U.S. at 270 (citation omitted). Some address abortion clinics specifically; others include those clinics in general regulatory regimes. Some require outpatient facilities to have doctors with admitting privileges at local hospitals; others require those facilities to have written transfer agreements with the hospitals. Many have varied combinations of these approaches. This is federalism at its best, where States may innovate through varied "solutions to difficult problems of policy." *Smith v. Robbins*, 528 U.S. 259, 273 (2000).

Petitioners, however, seek to supplant the States' diverse choices with their own—a one-size-fits-all approach in which abortion doctors, alone among medical professionals, get "veto power over [any] State's judgment" concerning any clinic regulation with which they disagree. *Stenberg v. Carhart*, 530 U.S. 914, 964 (2000) (Kennedy, J., dissenting); *cf. Casey*, 505 U.S. at 884–85. Petitioners assert, based on their opinions and those of like-minded

practitioners, that the Constitution prohibits States from requiring (1) abortion clinics to meet the same standards as other ambulatory surgical centers and (2) abortion doctors to have admitting privileges (or any other type of emergency plan other than calling 911). Pet. Br. 17–22. The Court has seen similar reasoning before: It "echoes the *Akron* Court's deference to a physician's right to practice medicine in the way he or she sees fit." *Stenberg*, 530 U.S. at 969 (Kennedy, J., dissenting); *see also Akron*, 462 U.S. at 455–56 (O'Connor, J., dissenting).

Michigan's experience proves this point for Petitioners' initial argument that the Constitution grants abortion clinics an exemption from ambulatory-surgical-center regulations. Pet. Br. 17–19. As noted, the Sixth Circuit invalidated a 1978 Michigan law that required abortion clinics to follow the same staffing, structural, and equipment rules that all other surgical outpatient facilities had to follow. *Reizen*, 743 F.2d at 364–66. When doing so, the court noted that the district court had *upheld* the rules because they did "'not *unduly burden* a woman's right to seek an abortion.'" *Id.* at 364 (emphasis added). The Sixth Circuit believed that "in utilizing the 'unduly burdensome' standard to evaluate these regulations the trial court employed an analysis no longer appropriate under *Akron*." *Id.* In other words, *Akron*'s physician-veto approach dictated the court's outcome—the same one Petitioners' seek here. That is confirmed by Justice O'Connor's concurrence in *Simopoulos*, which noted, under the undue burden standard, that the validity of a law requiring abortion clinics to follow

ambulatory-surgical-center regulations was not "contingent in any way on the trimester in which it is imposed." 462 U.S. at 520 (O'Connor, J., concurring).

Petitioners' second claim that Texas may not adopt an admitting-privileges requirement because, in their opinion, it "provides *no* health benefit to abortion patients" also follows from *Akron*'s physician-veto approach. Pet. Br. 19 (emphasis added). As noted, *supra* Part I.B.2, federal laws, accrediting organizations, and healthcare groups all identify admitting privileges as an uncontroversial option for ensuring that patients in outpatient settings "have immediate access to needed emergency or medical treatment in a hospital." 47 Fed. Reg. at 34086. Additionally, Ohio's experience shows that Texas would not have been free from litigation if it had chosen the other option—written transfer agreements. Ohio, for example, had to defend that requirement against suits asserting an undue burden on an abortion clinic. *See Baird*, 438 F.3d at 603; *Founder's Women's Health Ctr. v. Ohio State Dep't of Health*, Nos. 01AP-872, 01AP-873, 2002 WL 1933886 at *13 (Ohio Ct. App. 2002).

Petitioners hinge both of these constitutional arguments on the safety of abortions, alleging that those surgeries are as safe as others performed in physician offices. Pet. Br. 14–17. Yet the general safety of abortions no more warrants *Akron*'s preference for physician freedom than it did in *Casey*. That is especially true for the admitting-privileges requirement. After all, the whole idea

behind emergency plans is to prepare for rare situations. Even buildings that may never catch on fire must have smoke detectors, fire escapes, and fire drills. Indeed, Petitioners seek an exemption from best practices even in the *office-based* setting. There, too, healthcare organizations instruct practitioners to have privileges or a transfer agreement with local hospitals. *See supra* at 13–14.

Petitioners also argue that abortion is especially safe, and not even surgical, because it "involves no incision or suturing," but merely "entails insertion of instruments into a body cavity (the uterus) through a natural orifice (the vagina)." Pet. Br. 14–15. Their writing off of any risk conflicts with the claims of abortion doctors in the partial-birth context, who asserted that the prohibited procedure was safer because it reduced instrument passes and that "[t]he use of instruments within the uterus creates a danger of accidental perforation and damage to neighboring organs." *Stenberg*, 530 U.S. at 926. When abortion doctors seek a health exception to an abortion regulation, they highlight the risks of abortion; when they seek an abortion exception to a health regulation, they highlight its safety. That exemplifies *Akron*'s approach, which allowed those doctors unfettered choice in their medical practices.

In short, if the Court accepts Petitioners' premises, it will prove that not even the *Casey* framework itself "is safe from ad hoc nullification by this Court"—the very ad hoc nullification that the *Casey* framework sought to eliminate. *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476

U.S. 747, 814 (1986) (O'Connor, J., dissenting). When interpreted according to its terms, *Casey* permits—indeed, promotes—the health and safety laws at issue here.

II. Properly Applied, *Casey* Imposes No Heightened Standards For Health And Safety Regulations

Just because an abortion clinic is subject to health and safety regulations does not make those regulations subject to heightened scrutiny. *First*, general regulations that reach abortion clinics (among others) categorically fall outside the right to abortion explained in *Casey*. *Second*, health and safety regulations are valid—even when tailored to abortion—so long as the State has a "rational basis" for them, and they do not impose a substantial obstacle on the woman's ultimate decision to choose an abortion. Whichever category a law falls into, the same legitimate interests that justified the health and safety regulations upheld in *Casey* and *Gonzales* support the regulations at issue here. Abandoning *Casey*'s rational-basis test for those types of medical regulations in favor of Petitioners' heightened scrutiny would subordinate the State's health and safety objectives to the abortion business and overturn this Court's balance of interests that has prevailed for nearly 25 years.

A. *Casey*'s purpose-or-effects test was never intended for *generally applicable* laws that incidentally affect abortion clinics

Casey sets the parameters for review of abortion-*specific* statutes. There, the Court addressed Pennsylvania's "Abortion Control Act," which targeted abortion. *Casey*, 505 U.S. at 844. The Court held that laws like "Pennsylvania's abortion law," had to satisfy the "undue burden" standard. *Id.* at 887. The Court went on to apply that standard to other abortion-specific laws. *Gonzales*, 550 U.S. at 132 (Partial-Birth Abortion Ban Act of 2003); *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 323 (2006) (Parental Notification Prior to Abortion Act); *Stenberg*, 530 U.S. at 921 (state "law banning 'partial birth abortion[s]'"); *Mazurek v. Armstrong*, 520 U.S. 968, 969 (1997) (per curiam) (state "statute restricting the performance of abortions to licensed physicians").

Yet many States have enacted abortion-neutral health and safety laws that affect a variety of medical facilities or personnel, including those in the abortion industry. Since *Casey*, this Court has *never* applied the "undue burden" test to neutral laws just because they happen to regulate abortion clinics, like any other facility. In such circumstances, common sense and this Court's precedents require nothing more than rational-basis review, just as in other areas where neutral laws of general applicability incidentally affect constitutional rights.

In the First Amendment context, a general law that tangentially burdens protected speech is not subject to heightened scrutiny. *See Arcara v. Cloud Books, Inc.*, 478 U.S. 697, 706 (1986) ("[E]very civil and criminal remedy imposes some conceivable burden on First Amendment protected activities. One liable for a civil damages award has less money to spend on paid political announcements or to contribute to political causes, yet no one would suggest that such liability gives rise to a valid First Amendment claim."). This Court, for example, has "said repeatedly that a State may impose on the press a generally applicable tax." *Leathers v. Medlock*, 499 U.S. 439, 447 (1991). Similarly, the Court has held that neutral laws of general applicability incidentally burdening religious exercise need only pass rational-basis review under the First Amendment, not the strict scrutiny that applies to religiously targeted laws. *Compare Emp't Div. v. Smith*, 494 U.S. 872, 878–80 (1990), *with Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 531–32 (1993).

Likewise, under the Equal Protection Clause, rational-basis review, not strict scrutiny, applies to neutral laws that affect all races or sexes equally, even if they have a disparate impact on certain groups. *See Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 279 (1979); *Washington v. Davis*, 426 U.S. 229, 246 (1976). In that context the Court requires that the law have both a discriminatory purpose *and* a disparate impact to trigger heightened scrutiny. *Feeney*, 442 U.S. at 272. And the Court does "not assume unconstitutional legislative intent even

when statutes produce harmful results" on particular groups. *Mazurek*, 520 U.S. at 972.

Consistent application of precedent since *Casey* requires rational-basis review of abortion-neutral regulations as well. Any other path ignores the paradigm-shift wrought by *Casey*, which overruled the rule from *Akron* that heightened scrutiny applies to any law "touching" abortion. *See* 505 U.S. at 872, 874. *Casey* specifically criticized *Roe* and *Akron* for elevating abortion rights to a constitutionally unique status greater than any other rights: "As our jurisprudence relating to all liberties save perhaps abortion has recognized, not every law which makes a right more difficult to exercise is, *ipso facto*, an infringement of that right." *Id.* at 873.

Many neutral regulations prove this point. All ambulatory surgical centers in Ohio must store drugs and medical gases properly; maintain anesthesia records for patients; have procedures to obtain and store blood; have resuscitation and monitoring equipment; have an emergency call system; and have backup power. *See* Ohio Admin. Code 3701-83-19–20. All centers in Indiana must properly sterilize equipment; provide pathology and medical laboratory services; retain patient medical records; and implement procedures for administering anesthesia. 410 Ind. Admin. Code 15-2.5-1–7.

Rational-basis review makes sense for these laws—even when they impose costs that might deter more abortion clinics—given the chaotic

consequences of permitting an "undue burden" defense every time a clinic is shut down under a law that requires facilities to be safe, maintain records, or even pay their taxes. As Texas has explained, *see* Resp. Br. 4–5, its law requiring abortion clinics to follow the *same* rules as every other ambulatory surgical center seems to fall into this category as well. *See* Pet. App. 45a (noting that facilities "that provide abortions are treated no differently than any other" ambulatory surgical center). It would be an odd reading for the Fourteenth Amendment to give greater protection to the right to abortion than it gives to the right to free speech, free exercise, or racial equality.

B. Absent proof of illegitimate purpose, abortion regulations need only be justified by plausible legitimate interests

Some state regulations are unique to abortion. For example, in Indiana only physicians can perform surgical abortions, 410 Ind. Admin. Code 26-13-2(b), and abortion clinics may not use general anesthesia, 410 Ind. Admin. Code 26-13-1(c). Yet *Casey*'s heightened scrutiny does not stack the deck against the State's legitimate regulatory interests in that abortion-specific context. Rather, under *Casey* and its progeny, the serious battle is over whether that abortion-specific regulation imposes a substantial obstacle to abortion, not over the "necessity" for the regulation in the first instance.

A State has a "legitimate interest" in ensuring "maximum safety for the patient" in all medical

procedures, including abortions. *Roe*, 410 U.S. at 150; *see Casey*, 505 U.S. at 878. The Court's abortion-specific standards also "give[] state legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales*, 550 U.S. at 163. Accordingly, States can have a rational basis to act even when "medical uncertainty persists." *Id.* (citations omitted).

States, for instance, may require that only physicians perform abortions, *Mazurek*, 520 U.S. at 973, or that clinics provide certain information about abortion, *Casey*, 505 U.S. at 884–85. In those cases, no evidence conclusively established protection of maternal health, but the laws constituted valid exercises of the State's discretion. *Gonzales*, 550 U.S. at 163. Notably, in upholding the physician-only law, *Mazurek* rejected the challengers' invitation to review whether "all health evidence contradicts the claim that there is any health basis" for it. Rather than referee that scientific debate, the Court demurred that "the Constitution gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, even if an objective assessment might suggest that those same tasks could be performed by others." *Mazurek*, 520 U.S. at 973 (quoting *Casey*, 505 U.S. at 885). And in *Gonzales*, the Court expressly announced that "[m]edical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts." 550 U.S. at 164.

To the extent a regulation unfairly treats abortion clinics less favorably than comparable facilities, the rational-basis test provides sufficient protection to allow effective equal protection policing. *Cf. Planned Parenthood of Ind. & Kent., Inc. v. Comm'r, Ind. Dep't of Health*, 64 F. Supp. 3d 1235, 1260 (S.D. Ind. 2014) (invalidating prohibition against abortion clinic regulatory waivers "[b]ecause the State has provided no rational basis for this unequal treatment").

The Court should not construct a new level of scrutiny for abortion-specific health and safety laws.

C. When a plausible legitimate interest exists, a clinic regulation is invalid only if an "undue burden" results

Even if an abortion-specific regulation of the medical community has a rational basis, under *Casey*, a court must then ask whether it creates an "undue burden" on patients, *i.e.*, whether it "has the purpose or effect of placing a substantial burden in the path of a woman seeking an abortion." 505 U.S. at 877. This standard requires examination of a law's ultimate impact on a *woman's* ability to choose an abortion, not scrutiny of whether the law imposes "unnecessary" burdens on *doctors*.

1. Medical laws need only be reasonably related to patient health to pass muster under *Casey*'s "purpose" prong

Under *Casey*, the existence of a legitimate objective refutes any suggestion of invalid purpose. A law's purpose will fail only if the regulation "cannot be said [to] serve [any] purpose other than to make abortions more difficult." *Casey*, 505 U.S. at 900, 901. So, in *Gonzales*, 550 U.S. at 156–60, the Court concluded that the United States did not act with the purpose of imposing an undue burden because it had "a rational basis to act."

Petitioners, by contrast, propose heightened scrutiny of the "need" for every law. Pet. Br. 37 ("[A] Court should not blindly accept the rationale a state offers for an abortion restriction" because "[a] state could easily disguise impermissible efforts to hinder abortion as permissible efforts to promote women's health."). What *Casey* requires, however, is merely a reasonable relationship between the regulation and a health concern. 505 U.S. at 900, 901 (upholding reporting requirements that "relate to health"). Petitioners argue that "[u]nnecessary health regulations" constitute an "undue burden" under *Casey*. Pet. Br. 2, 37 But this is nothing more than an effort to repurpose a doctrinal formulation directed at a law's effects, not its underlying legitimacy.

Since *Casey*, the Court has never imposed a "necessity" requirement on an abortion health and safety regulation. *Cf. Gonzales*, 550 U.S. at 156–60;

Casey, 505 U.S. at 885 (noting the States' broad latitude). The Court in *Gonzales* specifically considered whether cases like *Stenberg* imposed a higher standard for abortion laws, but rejected *Stenberg*'s "zero tolerance policy" because it would "strike down legitimate abortion regulations if some part of the medical community were disinclined to follow the proscription." *Gonzales*, 550 U.S at 166. Such a standard would be "too exacting" because the legislature is competent to consider "marginal safety, including the balance of risks" presented by competing medical evidence. *Id.*

In this regard, there is no difference between abortion and other medical regulations. The Court has repeatedly said that States may confront health considerations in areas where scientific and medical evidence is disputed. In *Kansas v. Hendricks*, 521 U.S. 346 (1997), it said that psychiatric professionals' disagreement over whether pedophilia constitutes mental illness does not "tie the State's hands"; instead, "it is precisely where such disagreement exists that legislatures have been afforded the widest latitude." *Id.* at 360 n.3; *see also Marshall v. United States*, 414 U.S. 417, 427 (1974) ("When Congress undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad.").

Similarly, *Jacobson v. Massachusetts* upheld a mandatory smallpox vaccination law even though medical evidence did not conclusively establish that vaccination was the best way to prevent smallpox. 197 U.S. 11, 30–31 (1905). Courts cannot review

such legislative determinations unless the law has "no real or substantial relation to [the proffered health and safety objectives], or is, beyond all question, a plain, palpable invasion of rights secured by the fundamental law." *Id.* at 31. Otherwise, States have a duty to "choose between" "opposing theories" and enact health and safety regulations as they see fit. *Jacobson*, 197 U.S. at 30–31.

Whether the medical intervention relates to smallpox or abortion, a court reviewing medical regulations should be wary "not to rewrite legislation" just because the court prefers another alternative. *Hendricks*, 521 U.S. at 360 n.3 (quotation marks omitted).

2. A medical law that only incidentally affects patients passes muster under *Casey*'s "effects" prong

a. When addressing a regulation's effect, a court properly focuses on its *direct* impact on the ultimate right to choose an abortion, not its *incidental* impact when combined with other variables. *Casey*, for example, invalidated spousal notification laws because, it found, they *always* and *necessarily* put substantial obstacles between a "large fraction" of women seeking abortions and the abortions they sought. 505 U.S. at 893–95, 900. Spousal notification created an effective *veto* over the ultimate abortion right that *Casey* reaffirmed by barring many women from making the decision to have an abortion. *Id.* at 874. That, the Court said, was an unconstitutional effect.

Regulations designed to promote maternal health, however, are valid even when, if combined with other variables, they might make abortions more costly. *See Maher v. Roe*, 432 U.S. 464, 474 (1977). *All* regulations impose some cost-raising constraints, and the right recognized by *Casey* is not a right "to decide whether to have an abortion without interference from the State." 505 U.S. at 874, 875 (quoting *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 61 (1976)) (internal marks omitted). Rather, it is merely the "right to be free from unwarranted governmental intrusion" in having an abortion. *Id.* at 875 (citation and internal marks omitted). As *Casey* summarizes: "Only where state regulation imposes an undue burden on a woman's *ability to make this decision* does the power of the State reach into the heart of the liberty protected by the Due Process Clause." *Id.* at 874 (citations omitted) (emphasis added).

Under this standard, the Court has upheld not only informed consent and waiting period provisions, but also parental consent rules. *Casey*, 505 U.S. at 881–87, 899, 900; *Hodgson v. Minnesota*, 497 U.S. 417, 449 (1990). Both restrictions impose delays, and perhaps even out-of-pocket costs, on those seeking abortions, to the point where some women under particularly difficult circumstances may be deterred or even functionally prevented from obtaining an abortion. Yet the Court recognized such laws cannot be invalidated merely on the theory that they, along with other barriers, might cumulatively prevent a particular person from obtaining a particular abortion. *Casey*, 505 U.S. at 886.

The Court has also upheld a federal ban on a particular abortion procedure, *Gonzales*, 550 U.S. at 156, a state mandate that only physicians perform abortions, *Mazurek*, 520 U.S. at 971–73, and, even before *Casey*, laws requiring physicians to test the viability of a fetus prior to abortion, *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 519–20 (1989). While all of these laws had "the incidental effect of making [an abortion] more difficult or more expensive to procure," they were valid because they did not "strike at the right itself." *Gonzales*, 550 U.S. at 157–58. That is, they did not unduly impede the *ultimate* choice about whether to have an abortion. *Casey*, 505 U.S. at 874.

Similarly, Texas's medical regulations requiring abortion physicians to have admitting privileges at local hospitals and requiring abortion clinics to follow the same rules as other ambulatory surgical centers do not go to the heart of the woman's right to decide, and so do not have an impermissible effect.

b. Confining the *Casey* test to the *direct* effect of the *specific* regulation at issue squares *Casey* with the *Salerno* "no set of circumstances" standard for facial constitutional challenges. *See United States v. Salerno*, 481 U.S. 739, 745 (1987) (holding that a party mounting a facial challenge to statute must prove that "no set of circumstances exists under which the [challenged statute] would be valid."). Under that standard, the mere possibility that an abortion clinic regulation might be unconstitutional "under some conceivable set of circumstances" is "insufficient to render it wholly invalid." *Id.*

Before *Casey*, several cases had applied the *Salerno* standard to facial attacks on abortion regulations. *See Rust v. Sullivan*, 500 U.S. 173, 183 (1991); *Ohio v. Akron Ctr. for Reprod. Health*, 497 U.S. 502, 514 (1990); *Webster*, 492 U.S. at 524 (O'Connor, J., concurring). While *Casey* facially invalidated a spousal notification law on the ground that it would preclude abortion for a "large fraction" of women to whom it applied, 505 U.S. at 893–95, it did not upset the Court's longstanding preference for as-applied challenges over facial attacks.

The Court's later cases make that clear. *Ayotte* vacated a facial injunction against a parental notification statute that lacked a health exception. While *Ayotte* did not cite *Salerno*, it did apply the "'normal rule' that 'partial, rather than facial, invalidation is the required course,' such that a 'statute may be declared invalid to the extent that it reaches too far, but otherwise left intact.'" 546 U.S. at 329 (quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985)). Similarly, *Gonzales* upheld the federal Partial Birth Abortion Act against a facial challenge in part because plaintiffs did not prove that "every D&E," or even "the vast majority," "might violate the Act." 550 U.S. at 156. While not expressly reconciling the *Casey* "large fraction" test with *Salerno*, the Court clarified that as-applied challenges are appropriate for medical regulations—like those here—governing abortion doctors. *Id.* at 167 ("In these circumstances the proper means to consider exceptions is by as-applied challenge.").

It is no response to say that an "as-applied" challenge to a clinic regulation would be implausible given that no regulatory burdens could ever be connected to a particular woman's inability to exercise the abortion right. That observation merely highlights how far removed medical regulations are from the actual right to abortion protected by the Court's precedents. *Casey* employed the "large fraction" test based on its common-sense understanding of how an *abortion* regulation—spousal notification—would apply to abortion decisions in all (or nearly all) relevant cases. Notably, it did not apply the test to *medical* regulations, and it did not rely on empirical data demonstrating the operational impact of the notification requirement in a particular State. Rather, spousal notification was reviewed based on how it necessarily affected a woman's decision. As a result, the Court found spousal-notification requirements to be generally invalid, not merely invalid under circumstances where the requirements precipitate some threshold aggregate decline in abortions when combined with all other regulations in a particular area.

In Petitioners' view, by contrast, *every* regulation, whether it applies to the clinic, the procedure, or the woman, would be empirically tested in the aggregate against some undefined threshold of "access," such that the same regulation might potentially be valid in some jurisdictions, but invalid in others. That is not how the Court understood the standard in *Casey*, and it threatens a chaotic world of endless litigation leaving States, women, and physicians constantly

uncertain over the laws that can be enforced. After all, the Court did not permit state-by-state facial attacks as to whether a ban on partial-birth abortions had the effect of precluding abortion for a "large fraction" of women in a particular area. *Cf. A Woman's Choice-E. Side Women's Clinic v. Newman*, 305 F.3d 684, 688 (7th Cir. 2002) (Easterbrook, J.) (upholding Indiana's in-person counseling requirement because "constitutionality must be assessed at the level of legislative fact, rather than adjudicative fact determined by more than 650 district judges").

In short, only by limiting the "large fraction" test to particular abortion regulations considered *by themselves* (such as notification requirements or the lack of health exceptions), rather than to the *entire* regulatory landscape in an area, can the Court preserve the legitimate state regulatory role protected by *Casey* and maintain consistency with *Salerno* (and *Ayotte* and *Gonzales*).

c. Petitioners' challenge is predicated not on a specific Texas law's direct impact on a woman's ability to make the decision to have an abortion, but on the incidental and consequential regulatory costs imposed on clinics that have closed as a result of Texas's various regulations. *See* Pet. Br. 40. Yet, even aside from the fact that abortion facilities have no constitutional rights at stake, the impact of a regulation on the number and location of abortion clinics in a particular State is far too attenuated to be a sound barometer of "undue burden."

Any such impact does not *necessarily* follow from a clinic regulation. Existing clinics could become compliant, or new (compliant) clinics might open. The resulting abortion clinic matrix in a particular State is the result of an infinite array of federal, state, and local laws, individual proprietary decisions, local mores, financial circumstances, and other unknown (and unknowable) factors. The State and its laws do not create all conditions that contribute to the reduction or proliferation of clinics, or the resources of women to obtain an abortion under any particular circumstances. These are independently existing circumstances over which the State has no control. *Cf. Maher*, 432 U.S. at 474 ("The indigency that may make it difficult and in some cases, perhaps, impossible for some women to have abortions is neither created nor in any way affected by the Connecticut regulation.").

Under Petitioners' standard, a state law would be unconstitutional when existing clinics close but would become constitutional again when new clinics open. Unsurprisingly, in view of the temporal and geographic fluctuations that would follow, no constitutional doctrine holds that a valid regulation becomes invalid just because the accumulated burdens make exercising a constitutional right too difficult for some. Indeed, this Court has long held that its precedents do not compel States to provide abortions. *See Harris v. McRae*, 448 U.S. 297, 317–18 (1980); *Maher*, 432 U.S. at 474, 475–76. But Petitioners' standard would have no principled limit short of outright subsidization, contrary to these precedents.

Such a rule would in many respects echo the broad "sufficient providers" rate-setting standard employed by the Medicaid Act—a standard the Court just last term deemed incapable of judicial administration. *Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1385 (2015); *id.* at 1388 (Breyer, J., concurring in part and concurring in the judgment). In other contexts, even a regulation that "effectively prohibits" exercise of a constitutional right is not thereby invalid. *Int'l Soc'y for Krishna Consciousness, Inc. v. Lee*, 505 U.S. 672, 683 (1992) (upholding a ban on airport solicitations).

Petitioners' contrary and indeterminate "access" standard could jeopardize many vital and widely accepted abortion regulations, such as informed consent requirements, waiting periods, clinic licensure, and practice limits. *See, e.g., Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 162, 165 (4th Cir. 2000) (upholding regulation requiring abortion clinics to become licensed even though at least one clinic would likely close); *Karlin v. Foust*, 188 F.3d 446, 487 (7th Cir. 1999) (upholding 24 hour waiting period and face-to-face informed consent requirement notwithstanding decline in abortions).

There is no justification for affording preferred treatment to abortion rights by unleashing on each State the unwieldy inquiry of whether clinic regulations permit adequate access to abortions. Doing so would overturn the calculus that recognizes a right to abortion but also protects the States' valid interests in protecting the mother's health and

safety—an interest that *Gonzales* said "must not be set at naught." 550 U.S. at 158.

3. Petitioners cite no evidence that abortion regulations prevent women from obtaining abortions

The entire premise of Petitioners' undue burden theory is that Texas's clinic regulations will prevent women from obtaining abortions. Yet, despite decades of those regulations, neither Petitioners nor their supporting *amici* provide any evidence of such a stark result. The most that they prove is that, in the wake of new state regulations, some abortion clinics close rather than adjust. They recite no evidence that such closures have prevented any women from obtaining a timely abortion.

Petitioners, for example, say the Texas laws reduce abortion access because the number of providers decreased by 75% after the laws became effective. Pet. Br 23–25. Supporting amici make similar arguments from indirect inferences. *See, e.g.*, Brief of *Amici Curiae* National Network of Abortion Funds and 41 Member Abortion Funds in Support of Petitioners at 14–17. None of that data, however, proves that medical regulations *actually* prevent women from having abortions. And the lack of any such proof is significant because clinic regulations are not new. *See* Part I, *supra*. If such regulations were a problem, surely ample data could be cited to support that conclusion.

Of course, none of this is what the undue burden standard is really about. An undue burden exists only when a law directly interferes with "a woman's ability to make [the] decision" to have an abortion and *necessarily* puts a substantial obstacle in the path of a "large fraction" of women for whom the rule is relevant. *Casey*, 505 U.S. at 874, 895, 900. *Casey* itself rejected the argument that regulations create a "substantial obstacle" merely by increasing the marginal costs of abortion and thereby reducing access to abortion for some women. *Id.* at 886. Accordingly, particularly where, as here, there is no data demonstrating any actual decline in abortions resulting from otherwise legitimate regulations, the "undue burden" standard is beyond reach.

CONCLUSION

The decision below should be affirmed.

Respectfully submitted,

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